MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Harris Methodist Ft. Worth P.O. Box 916063 Ft. Worth, TX 76191-6063	MDR Tracking No.: M4-03-8661-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address TML Intergovernmental Risk Pool/Rep. Box #: 19 C/o Flahive, Ogden & Latson 505 West 12th Street Austin, TX 78701	Date of Injury: Employer's Name: City of Gainesville Insurance Carrier's No.: T080200074180

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10-10-02	11-13-02	Inpatient Hospitalization	$29,157.00	$00.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor's position statement of May 30, 2003 states "… We do not believe the reduction is justified… such provider reimbursement rates must be adjusted based on the usual and customary treatment charges for that specialty and the geographical region where treatment was provided… Reimbursement for services not identified in an established fee guideline shall be reimbursed as fair and reasonable rates as described in the Texas Workers' Compensation Act, 8.21(b), until such period that specific fee guidelines are established by the Commission…" The Requestor rationale on the Table of Disputed Services states "should of pd 34 days x 1118.00".

PART IV: RESPONDENT'S POSITION SUMMARY

Respondent's position statement of August 4, 2003 states "This dispute involves DOS 10/10/02 and carrier paid $46,915.00 of a $65,940.00 bill leaving $29,157.00 in dispute… the provider failed to show that the services provided were unusually extensive, unusually costly and/or arose from an unusually lengthy stay… TML-IRP correctly calculated the amount owed for these dates of service and no additional reimbursement is owed to the provider…".

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in a hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). In this particular admission, the principle diagnosis code was 890.1 related to trauma care for "Open Wound of Hip & Thigh Complicated" (as listed on Corvel's Explanation of Review). Pursuant to Rule 134.401(c)(5), the reimbursement for the entire admission shall be paid at a fair and reasonable rate as neither the per diem method nor the stop loss method apply to this case.

Determining the "fair and reasonable" reimbursement can be difficult. In this case, it appears that neither the requestor nor the respondent have persuasively shown that their position represents the appropriate amount. Therefore, an alternate approach is needed to determine the reimbursement amount.

Based on the data contained in the Commission's medical billing database for dates of service in 2002, trauma admissions were reimbursed, on average, at 55.5% of the total charges (total payments divided by total charges). Applying this same formula to this specific case appears to be a sound method to determine the appropriate fair and reasonable reimbursement.

Accordingly, the health care provider is entitled to a total reimbursement amount of $36,597.12. This was calculated by multiplying the total changes of $65,940.77 by 55.5%.

Since the carrier has previously paid $46,915.66, the health care provider is **not** entitled to additional reimbursement.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Decision by:

	Roy Leiws	4-27-05
Signature	Typed Name	Date of Decision

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, 7551 Metro Center Drive, Suite #100, Austin, Texas 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____